Government of **Western Australia**
Department of **Health**

Destination: Sustainability

Clinical Senate of Western Australia

20 November 2017

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Overview

The final meeting of the Clinical Senate of Western Australia (WA) for 2017 was held on 20 November at Fraser's Function Centre, Kings Park, WA.

The topic for debate was "Destination: Sustainability".

In March 2004, A Healthy Future for Western Australians: Report of the Health Reform Committee (the Reid Report) identified strategic directions for the WA health system. The recommendations endorsed by the State Government, included a number of major infrastructure projects and other initiatives that mapped out health reform for the following decade.

In 2017, the WA health system is the largest single source of expenditure in the WA State Budget, representing 30 percent of expenditure in 2016-17 compared to 24.9 percent in 2008-09 (Cook, R. 2017).

The growth in the cost of healthcare has not been accompanied by an equivalent increase in services to the community or improvement in health outcomes. WA's health system continues to face challenges associated with an increasing ageing population, increased rates of chronic disease and health inequity as reflected in the Reid Report but recommendations addressing these issues have not been fully implemented. Within the constrained budgetary environment, new solutions must be sought to meet the future health needs for all West Australians.

In June 2017 the Government of Western Australia announced the Sustainable Health Review (SHR) http://ww2.health.wa.gov.au/Improving-WA-Health/Sustainable-health-review with an independent Chair, Ms Robyn Kruk AM to consider how the WA health system can continue to provide patient-first, innovative and sustainable care for years to come. Ms Kruk agreed to be Executive Sponsor of the Clinical Senate debate.

This debate first focussed on key learnings from the 2004 Reid Report, before considering priorities for the system going forward and metrics to drive system change. A pre-debate survey issued to Clinical Senators and Alumni provided opinions on the progress from the Reid Report, as an opportunity to learn from previous reform.

Present at the debate were a range of experts from across the health services, health service boards, universities and community and primary care. Participants also included members of both the clinician and consumer and carer SHR reference groups and the WA High Value Healthcare Collaborative.

Aims

The aims of the day were to hear from the collective voice of clinicians to:

a) engage clinicians in discussion around the recommendations of the Reid Report on what worked and what didn't work;
b) provide the opportunity for senators to contribute to discussions around the SHR and;
c) determine a range of metrics for system change.

Process

Three sessions aided in achieving these aims.

Part A: Consultation on the Reid Report

To facilitate discussion on the Reid Report, participants were asked to complete a pre-debate survey.

Following this, presentations and plenary discussion on the day of the debate led to feedback on what worked and what didn't work. Senators, experts and guests worked in small groups to answer the focus question:

What blocked implementation of Reid that might have changed models of care?

Participants used group map to list their feedback. This combination of process permitted an insight into perceived blockages and identified opportunities to reform models of care.

Blockages identified by clinicians included a lack of political will, a lack of strong and stable leadership and a failure to understand how long it takes to embed change. Furthermore, financial structures that have not supported innovation have had an impact.

Part B: Consultation and discussion on sustainability

To contribute to discussions on the SHR, Senators heard from Ms Robyn Kruk AM, Dr Hannah Seymour and Ms Pip Brennan who presented on the main aims of the SHR and outcomes of consultations with clinicians, consumers and carers to date.

Using group map technology Senate participants, working in small groups, explored what a sustainable health system would look like.

In the plenary debate senators were encouraged to further unpack what sustainability in health should look like and to consider the themes and metrics required for system change and state wide benchmarking.

A summary of the key messages from this plenary can be found in the main body of this report.

Part C: Metrics for system change

To inform metrics for system change, the Facilitators - Clinical Adjunct Associate Professor Kim Gibson and Mr Will Bessen - posed the following statement for completion by participants:

> *We will know we have a sustainable health system when…*

Using group map technology senators worked in groups to complete this statement and, after doing so, to discuss and put forward metrics for their completed statement. Their discussions were organised into the six SHR themes:

- Patients, Pathways and Experience
- Prevention, Promotion and Partnerships
- Quality and Value
- Workforce and Culture
- Financial Sustainability
- Digital, Innovation and Research

There were in excess of 250 metrics identified as measures of success in establishing and measuring a sustainable health system.

Completed statements under these themes and the diversity of recommended metrics can be found in the main body of the report.

As anticipated, this final debate for the Clinical Senate in 2017 achieved broad clinician engagement beginning with lessons from Reid and culminating in clear recommendations for the SHR with potential metrics for system change across the WA health system.

Report in full

Presentations

Welcome and Chair's address

Ms Marie Taylor, Nyungar Elder opened the session and offered a Welcome to Country.

Ms Tanya Basile, Chair of the Clinical Senate opened the debate. In updating members on the Clinical Senate since the last meeting Ms Basile welcomed three new executive members: Ms Jenny Campbell, Ms Kate Reynolds and Dr Jagadish Krishnan who bring a wealth of knowledge and experience to the senate executive. Ms Basile reported she had also met with the Chairs and Chiefs of all of the health services/ boards to discuss the senate process and how to best implement strategies to strengthen working relationships.

She thanked Ms Kruk for her leadership in preparation of the debate and recognised the value of using the Clinical Senate as a prominent source of clinical advice for the SHR. She stated the opportunity today is to engage clinicians in the SHR with the aim of developing metrics to ensure a safe and effective system going forward.

Ms Basile advised that the Senate had been charged with reflecting on the successes or otherwise of the Reid Report and challenged to identify measures of success in the establishment of a sustainable health system.

Ms Basile provided the results from the pre-debate survey whereby, using a Likert scale and free text. Senators and Alumni members responded to the following seven statements:

1. Clinicians are directly involved in the strategic planning process in their particular service area.

49% strongly agree/agree - 44% strongly disagree/disagree

Comments included:

- *that planning usually only involves high level clinicians comprising mainly of doctors;*
- *the voice of junior doctors appears to be silent in most arenas;*
- *and doctor's involvement is stronger than nurses and allied health.*

2. Clinicians feel a sense of ownership in helping direct the current and future clinical issues to establish the clinical priorities from a collective focus.

32% strongly agree/agree - 58% strongly disagree/disagree

Some feedback stated that:

- *Clinician and corporate governance is two sides of the same coin.*
- *Clinicians need to come on board with the understanding of the importance of monitoring and reporting.*
- *The challenge is how we can manage value over volume in the Activity Based Funding (ABF) environment.*

3. Clinicians are accountable via performance monitoring and benchmarking, thus driving long-term performance improvement.

41% strongly agree/agree - 47% strongly disagree/disagree

Feedback reported was as follows:

- *"Clinicians who are self-interested and critical for no reason need to move on."*
- *"If you are not part of the solution you are therefore, part of the problem."*

4. Clinicians are encouraged to support health service initiatives in a collaborative manner around all aspects of health service performance.

39% strongly agree/agree - 46% strongly disagree/disagree

- "*Networks between health services appear to be broken again and health service boards need to collaborate, cooperate and drive partnerships."*

5. Clinicians are vested in WA Health's success.

61% strongly agree/agree - 20% strongly disagree/disagree

- *"Plans move very fast however, consultation takes time. These need to be considered as we want to get it right!"*

6. Clinicians can advocate for patients and give constructive criticism without fear.

46% strongly agree/agree - 44% strongly disagree/disagree

- *"There is the risk of chasing the dollar. Balancing budgets and the widening gap between service delivery and patient experience is a reality. This split could indicate we have areas where it is working well but lacks consistency."*

7. The current clinical governance processes are meeting the needs for the delivery of health services in Western Australia.

32% strongly agree/agree - 49% strongly disagree/disagree

The free text comments by clinicians recognise the tremendous changes experienced by the health system for more than a decade. The enactment and subsequent implementation of the Health Services Act 2016 has created a sense of competition not collaboration between HSPs. Having now defined and implemented the structure, Ms Basile acknowledged it is time to strengthen collaboration, share success and learnings across all providers of health services. There is now the need for stability.

The final section of the pre-debate survey sought further comment in the form of "free text" where the following statements were made:

- *"In the name of good governance, bureaucratic processes are paralysing innovation and the ability to redesign or re-engineer"*
- *"147 days for approval for recruitment of positions is ridiculous"*
- *"Doctors still have the strongest and loudest voices"*
- *"Strategies to measure value not volume must be identified"*

Ms Basile then shared the following comments with regard to lessons to take forward with the implementation of the SHR Report:

- The SHR needs to be more than words on paper
- The SHR needs to value add for clinicians and patients
- There needs to be feedback and transparency - not just going through the consultative phase but through the Plan Do Study Act (PDSA) cycle
- If the majority of clinicians remain disengaged the momentum for change sits with a few which leads to burnout
- The proportion of part timers in public health and the public health system is a risk to sustainable change
- Where we can, learn from other states e.g. Medicare

She advised participants how the senate conducts business stating we seek to:

- work collaboratively, setting aside individual and organisation agendas
- encourage senators to state opinions freely, drawing on clinical experience and expertise
- empower participants to influence others in all professional spheres with the new perspectives gained through the debate
- play a leadership role in health reform, and improve the safety and quality of health services
- share under Chatham House rules

In closing, Ms Basile reminded all participants that current expenditure of $8.9 billion for health services in WA is considerable and health simply cannot afford to continue to spend at this rate. It is time to reimagine health care and to begin the conversation of a radically different future. She then asked senators to consider how to determine metrics based on the six main themes from the SHR Panel in response to the key question:

We know we will have a sustainable health system when…

Director General's Response

Director General, Dr David Russell-Weisz spoke next reporting on the top 10 of the endorsed clinical indicators as determined by Senators at the previous debate: A Holistic View of Quality and Safety (July 2017). He reminded senators that safety and quality for patients and experience as individuals, is the most important thing we do and thanked the senate for their advice in this area. The debate was specifically scheduled post release of the Review of Safety and Quality in the WA health system conducted by Professor Hugo Mascie-Taylor. Senators were provided the opportunity to be briefed on the Review of Safety and Quality in the WA health system and then determine the 20 most useful indicators at a system level. All 20 indicators were accepted, recognised as a high priority for the Department and are being considered by the Safety and Quality Leadership Group. All of the senate indicators would go into the mix and will inform a new health service report that boards report on and will form part of the performance frameworks. The indicator set will be ready for distribution in 2018.

Finally, he reported that WA was the first health system in Australia to roll out Patient Opinion across every health service.

Turning his attention to the topic of the day Dr Russell-Weisz asked participants to "*call it as it is and don't leave the room not having addressed the challenge and importantly, not saying it!*" SHR is not just financial but rather links the three elements of what we do: safety and quality; value and experience; and clinical and financial performance. The SHR is about setting up the future for 1-3-5-10 years on. It is about swinging the pendulum away from our hugely dependent tertiary hospital care to better care. It is not dissimilar to what Reid said - it is about leveraging the investment in the system.

Dr Russell-Weisz stated that Health utilises 30% of the state budget. WA costs are currently 22 % greater than the national efficient price. He noted that 60% of the health budget is within the state's control in relation to services provided within hospital settings. While there has been some progress to reduce the financial growth from 10-12% increase to 3-4% increase, growth in costs without efficiency gains and better outcomes must be arrested.

He reported the SHR had received 350 submissions from organisations, individuals and interested community groups. This represents the diverse interest in ensuring the future system is sustainable.

He called on senators to realise their opportunity to inform the SHR and the subsequent framework for a new 10 year state plan. This topic became a priority for the Clinical Senate because it is of extraordinary interest; this is a huge priority for the system, a priority for government but will fail without clinician engagement.

Dr Russell-Weisz introduced Ms Robyn Kruk AM Independent Reviewer (Chair) who was appointed by the Minister for Health to lead a review of the WA health system in order to prioritise the delivery of a patient first, innovative, high quality and financially sustainable healthcare system for all Western Australians.

Ms Robyn Kruk AM Independent Chair, Sustainable Health Review

Ms Robyn Kruk AM set the scene for the debate stating the clear mandate from the Minister was to undertake thorough consultation and to put forward preliminary recommendations on the basis of consultations such as the senate meeting. The need to look back at Reid was to learn from history.

The SHR will consider the needs of the people utilising the health system, the outcomes of that system and whether spending is efficient, with the focus always on better value care and minimising inequity.

She stated there must be a better way of ensuring good outcomes for all West Australians – not dependent on post codes, not by the door you enter the system through and not actually depending on your presenting conditions. The system is incredibly complex, even seasoned professionals don't know or understand the intercept between NDIS, mental health etc. We ask members of the community to understand very complex aspects of the system without a clear roadmap. Ms Kruk raised other issues related to value and workforce and the need to have accurate data on clinical outcomes. WA is now the state with the biggest debt and in effect the budget situation will put a cap over future growth in health expenditure. The role of clinicians is to identify cost variation, outcome variation and workforce utilisation using accurate and robust data. Ms Kruk stated her plea was for Senators to 'call it straight' and give direction in terms of where they think things needed to change in order for WA Health to be sustainable. These could be rules, practices or behaviours. She stated that the 7 billion dollar investment in infrastructure is only part of the equation and that in many ways your journey starts here, beyond the bricks and mortar. It is about culture which actually cements the role of the person who uses the health service.

The state government is moving to an outcomes based approach and there is the need to look beyond the boundaries of WA Health as there are many pivotal interactions outside of the health system. Ms Kruk asked senators to also consider the behavioural changes that may be required to ensure ongoing innovation across the WA health system.

Ms Kruk closed with the following comment "*What makes this group powerful is your diversity through experience and discipline and I thank the Senate Executive for the opportunity to sponsor this debate".*

The Clinicians perspective

Dr Hannah Seymour, Chair, SHR Clinical Reference Group provided the clinician perspective. She stated the SHR would provide outcomes for WA Health to map a way forward ensuring the most patient focused, innovative, and financially sustainable and exemplar health system is achieved in WA.

She described the health system at the time of the Reid Report, shared responses to the pre-debate survey on the outcome of Reid and identified a number of the challenges still faced today. She also provided an overview of the SHR consultations to date.

Providing perspective since Reid, Dr Seymour stated that in 2003 there were no smartphones and the Reid Report did not even mention smartphones or digital health. She recalled being a registrar and the only perceived impact of Reid was in relation to the proposed closure of Royal Perth Hospital and the building of a hospital in the south. It was however more than buildings. "I stand here today realising the Reid review did change my career. As an outcome of a Reid recommendation I ended up in a leadership position in falls prevention and am now in a leadership role at Fiona Stanley Hospital".

Comparing the processes of the development of the Reid Report with that of the SHR, Dr Seymour shared that preliminary submissions for Reid equalled 28, with several more received after the interim report. To date the SHR had received 350 submissions. Additionally, during Reid, the clinical reference group consisted of doctors only whilst today doctors on the SHR advisory groups represent only 50% of the membership.

Dr Seymour outlined the format of the pre-debate survey as one that included key questions around implementation of the recommendations from the Reid Report that led to sustained improvement under each of the main themes: population health, primary and community care, hospital services, system efficiency, workforce, and accountability, resource allocation and governance.

She reported that respondents totalled 59 inclusive of senators or proxies, alumni and others. Two thirds were from the metropolitan area, there was a good spread across disciplines, most work in the public system and all were very experienced.

Dr Seymour reported there was a dichotomy to many of the questions and suggested that comes back to the progress clinicians thought had been made in some of those areas and whether they felt the progress was sufficient to say the recommendations had been achieved. Expectation vs reality!

In relation to the key questions: whether or not implementation has led to sustained improvement; why/why not implementation was achieved; and the lessons learned, Dr Seymour reported on key Reid Report domains as follows. For:

Population health, primary and community care

Given the 49% increase in emergency department presentations and 39% increase in admissions, overall improvements in this domain had not been achieved. Most felt that the reasons were complicated but in the case of COPD, linkages were in place however, funding was not continued. Dr Seymour stated this suggested the need to consider how to drive change from acute services to sustainably funded community services.

Other comments related to a lack of evidence of programs and the need for a much stronger focus on working with Non-Government Organisations (NGOs) and other organisations to support community care and population health. Finally, there were many programs that showed great promise (impact) yet funding was discontinued.

Hospital service redesign

Dr Seymour reported an even split amongst senators who agreed vs disagreed depending on how many services they felt had been implemented. For example when thinking about renal transplant, Reid recommended one centre but today there are two centres operating. I ask you to consider if that is enough to say that we achieved some of those recommendations.

System efficiency

Dr Seymour reported that senators strongly felt the system was more efficient. Reid did talk about how length of stay (LOS) had plateaued however; she reported that as a State this was not true as LOS has been massively reduced. In fact, she stated this was certainly one area of improved efficiency and WA now had the shortest LOS in all of Australia.

Workforce

Reporting on the implementation of the recommendations in relation to workforce overwhelmingly, 70% agreed that improvements in this area have not eventuated from Reid. She stated there were several comments about morale and engagement as well as innovation and as previously mentioned, it highlights just how difficult it is to innovate in our system. Additionally, there were many comments about the balance of power. Dr Seymour reported efforts have been made to ensure engagement and consultation with clinician through the SHR process.

Accountability, Resource allocation and Governance

58% of senators agreed/strongly agreed with recommendations focussing on accountability, resource allocation and governance. General comments shared by clinicians for this section conveyed that measuring and benchmarking are the keys to governance and accountability. Other comments presented by Dr Seymour included:

> *"I see data collection and investigation of adverse events and complaints. That is good. There needs to be more action to address the root causes of the problems. Action to prevent recurrence is often limited to production of a new guideline or pathway or presentation to your colleagues to highlight risks or problems. More needs to be done."*
>
> *"In my middle-management position, I see clear evidence of my Board showing accountability in performance and governance and insisting on it being provided by my Hospital. I don't see huge medical workforce engagement in governance however. Financial systems at my hospital are poor and HR is so slow that it is the biggest risk to clinical flexibility and improved performance. Research is leaving town."*
>
> *"There is an increase in reporting - but I would contend that the next stages of this process are critical in embedding quality improvement and clinical governance in the 'health care culture' promoting innovation, quality improvement and development of patient-centred and - driven care rather than defensive, risk averseness."*

Dr Seymour next shared that major themes from the SHR clinical and community consultations to date were emerging as follows:

- Being clear about what can reasonably be provided by regional health providers and managing community expectations accordingly.
- Decisions need to be made about the way in which services are provided in the regions and the need for increased collaboration between providers.
- Investment in preventative health, primary care and community services should be increased
- Funding reform
- Improved application and use of digital technology
- Regional workforce – attracting the right people, improving capacity and ensuring staff wellbeing and addressing the need to fill these positions in a shorter timeframe (149 days)
- Challenges associated with providing adequate mental health services in regional or remote locations
- Additional pressure on regional services resulting from an ageing population.

Dr Seymour stated, upon reflection, the metrics used to measure the impact of the Reid Report may not have related entirely to the intended changes. This important lesson underlies the intentions of the Senate debate.

The Consumer and Carer perspective

Ms Pip Brennan, Chair, Consumer and Carer Reference Group SHR addressed consumer and carer engagement in the SHR to date and shared her view of what consumers' want.

Ms Brennan spoke of the role and responsibility of the reference group, its links to the SHR Panel and critical issues around engagement. The main outcome for the Reference Group was for recommendations that lead to system change, and supporting a sustainable, person-centred health system. She outlined the complex nature of the review and identified multiple sources of consultation feeding into the interim and final reports including forums, public submissions, staff surveys, reference groups, engagement strategies, person centred services project and various working groups. Ms Brennan provided an overview of the number of consultations undertaken and emphasised the need for patient centred services that also address disability, mental health and aged care.

Ms Brennan stated as Chair of the reference group although reports are important, the key outcome is 'change'.

The Consumer and Carer Reference Group has identified a range of issues. Consumer engagement must allow time for knowledge acquisition, reading time, active participation, working groups and appropriate compensation. It must also reflect alternative methods to garner the voice of the consumer. An example of this is a specific project by the Health Consumers' Council (HCC) to reach more 'people on the street'. All programs requiring consumer input must have realistic timeframes to allow consumer participation through a variety of modalities.

Ms Brennan emphasised the importance of getting real public representation and engagement at the grass roots level. This was evident by the limited consumer/carer involvement in the SHR public forums where 25% of participants were consumers; 64% health care providers and 11% undeclared. She highlighted the fact that there had been more participation by non-government organisations that are not fully representative of consumers.

In addressing what consumers don't want, Ms Brennan stated the key message was to not place blame on the patient. She offered the following quote *"If we want people to take more responsibility for their health … we need to equip and empower them to do so – telling them they need to do something isn't enough".*

In addressing what consumers want with regard to sustainability she shared the following:

- Using the required funding and appropriate resources in the most culturally effective way to meet our communities' reasonable current health education and service needs and expectations while, at the same time, enhancing the State's ability to meet the reasonable short, medium and long-term future health needs and expectations of the entire WA population.
- Healthy communities, healthy people and healthy planet.
- 3 pillars of sustainability, people (social justice), economic, environmental.
- Recognising the finite resources; human, environmental, financial and societal, and ensuring the health needs of all West Australians and West Australian communities now and into the future, can be met.

Consumers want more action, inclusive of social determinants and a shift to preventative health care. They want transparent reporting on implementation of recommendations and transparent reporting of what has been achieved. Consumers do not want waste so the SHR is bringing together the key initiatives combined with High Value Healthcare, Choosing Wisely and the Review of Safety and Quality in the WA health system to ensure all of these parts are talking and working together, informing each other and not being ignored. "It is really important that the wisdom of the group is combined".

In closing, Ms Brennan emphasised the need to 'change the game' from one of a clinician only voice to that of embracing new modalities to engage consumers like utilising citizen's juries. Without these changes we will continue to have the same conversations with government and non-government and undervalue the disruptor ability of the consumer and the opportunity of consumers to drive change.

Consultation on the Reid Report

While a range of the Reid Report recommendations were successfully implemented over the past decade, senators used group map technology to identify what had not been implemented successfully and provide feedback on the following focus question:

What blocked implementation of the Reid Report that might have changed models of care?

Responses from senators included:

- No funding models carrying the patient from the community to a tertiary or secondary health service and back into a primary care setting;

- Poor linkage from rural into metro services;
- Continued focus on the acute sector and diminishing funds for population health and effective prevention;
- Organisational culture;
- Need for early and sustained staff engagement in change;
- Identification of change champions;
- Leadership is a balance of keeping people engaged and budgets in line;
- Lack of transparency of data to drive change;
- Lack of incentive for IT hardware and software providers to provide an integrated service;
- Political will was lacking;
- Lack of shared electronic records across systems, unable to link hospitals with mental health, Aboriginal Medical Services and private providers for primary care coordination and referral;
- Too many recommendations and projects. This cluttered the line of sight necessary for reform, compromising clear monitoring, accountability and communication of recommendation implementation;
- Health literacy is lacking. Community understanding of the structure, functions and inefficiencies of the health systems is insufficient. Poor understanding means that the public as an ally in reform didn't hold those responsible for implementation to account. There was not enough transparency and education;
- There is no consistent workforce strategy;
- Poor communication following the Reid Report to front line staff and no feedback loop on the recommendation for implementation and its progress;
- Focus on infrastructure rather than service;
- Linkages with primary care as a system largely funded by the Commonwealth Government were truly not established;
- Generalism vs subspecialties. Aging population - need more generalists as there is no evidence of improved outcomes if they only have specialists. Leads to other problems (e.g. rostering and staffing of hospitals);
- Lack of strategy to support development and integration of new models of care and to ensure focus was not just hospital investment;
- Lack of timeframes for action of the recommendations (i.e. not SMART); and
- Failure to drive change around State and Commonwealth investment in primary/ preventative care. Lack of consistency and attention to the outcome and driving it regardless of political agenda, by both Health and Treasury. Need to invest more in skillful negotiation at executive level in Health and Treasury and staying with it until the best outcomes are obtained for the people of WA.

On the basis of this analysis, advice to the SHR from the Clinical Senate of WA with regard to the Reid Report outcomes is not surprising. As in any reform process, there needs to be a clear statement of purpose and continuous communication across the system with all stakeholders including consumers, clinicians, managers and other government departments including the Commonwealth Department of Health. There must also be better management of expectations. In addition timeliness proved important, as did the need to underpin reform within WA health system with alignment of funding so that the needs of the patient drove improvements in the system (where treatment occurs). An absence of clear outcome statements with which stakeholders could support and evaluate implementation in partnership with the WA Department of Health left a legacy of perceived confusion. Nonetheless, successes are evident.

This information helped to further inform discussion during the plenary debate.

Plenary – The critical conversations

Facilitator Gibson opened the plenary reassuring participants that everyone had an opportunity to be heard. The Clinical Senate practices Chatham House rules. She encouraged open constructive debate: *"This is your opportunity to contribute in a very tangible way to the SHR".*

Mind Map technology was used in order to organise and support the robust discussion. The mind map also created the mechanisms to validate whether the themes for sustainability from a clinician's perspective were similar to or different from those identified by the SHR. The plenary discussion was enriched through the Senate process of providing senators with pre-reading prior to the debate, presentations by keynote speakers and inviting experts in the field to join in the facilitated plenary discussion. This identified what was needed to be measured and ensure success.

The mind map documented key feedback from the plenary discussion and became the foundation for development of the key recommendations and suggested metrics for the SHR.

The plenary was focussed on allowing clinicians to unpack the issues identified around the Reid Report (refer previous section comprehensive list) and what remains important to future sustainability. Senators then identified what was required for both short and long term sustainability of the health system.

There were challenges to the success of **strengthened community care.** This was a main theme throughout Reid and yet had minimal implementation success over the past decade. What had prevented the establishment of stronger and broader relationships between public and private providers and the establishment of stronger links with NGOs and other health service providers? One identified cause was the complexity of funding models and also the lack of financial acumen to embed innovative changes requiring continued funding into the way we do business.

Both the clinician and consumer voice was loud around **waste in health**. One example cited - in practice, it is quicker to repeat a test than to seek out the results.

Another reflection offered was that services are not rewarded when they translate research into practice to improve an outcome for patients or to de-invest in proven money and time-wasting practices. Why is there an option to participate or not?

This debate challenged our depth of **consumer engagement** and our willingness to influence and implement the changes required. Frustration occurs when reality does not meet expectation. Messages from health services and health providers need to be clearly articulated, realistic and understood. Vison and goals should not be confused. The use of Goals of Care and Advanced Healthcare Directives may eliminate waste in health services.

Clinicians recognised waste in health and in addressing **financial sustainability** the following needed to be actioned:

- Reduce duplication of tests (re-bleeding) due to training and public private divide and inability to share
- Use test ordering formularies as part of the model of care
- Identify the financial waste when clinicians are over-engaged in administrative tasks

An equally strong theme was around the inconsistent use of end to end clinical and **evidenced based service** models focussed on quality of service that considers safety results and importantly, are proven to provide better outcomes and lower costs.

Throughout the plenary speakers from the floor reflected on a sense of **disconnected care** and the fact that both consumers and clinicians remain 'hospital centric' and that hospital centric care is expensive.

Another issue identified in the plenary was the retention of clerical support to ensure the more expensive workforce was deployed efficiently.

In discussing opportunities for **innovation,** clinicians identified the need for investment and engagement with staff overall in terms of how to support staff with benefits and savings realised through this approach. There was strong support to move the distribution of pay slips to an electronic mode.

The fact that we appear 'hooked up' on the implementation of **telehealth** with little or no vision around the broader capabilities now offered by NBN is cause to question where the vision is for expanding home monitoring or virtual hospitals.

Finally, sustainability across the whole system requires an assessment of the key interactions between components of the system including hospital (state-funded) and community-based (largely Commonwealth-funded) components.

The robust discussion throughout the plenary revealed similar themes to those identified by the SHR in other forums. The debate again created the opportunity for clinicians to question the unfinished business from the Reid report and a strong theme was the need to strengthen leadership and accountability for deliverables if the changes to be recommended through the SHR were to be successful.

The discussion points ordered under the SHR themes allowed smaller working groups to delve deeper into the points and determine what changes needed to be made and to apply a metric to measure its success.

Key messages raised in the plenary around the six SHR themes included the following:

Patient, Pathways and Experience

- Person centred approach
- Adopt the "Choosing Wisely" recommendations
- Current Models of Care (MoCs) lead to 'ownership' of patients and silos of practice – consider better coordination of care
- The importance of strengthening the role of primary care
- GPs are the gateway to the rest of the system
- Complex system for carers and patients to navigate

Prevention, Promotion and Partnerships

- Place based solutions to realise innovation locally
- Health of our children in the first two years of life is critical for the sustainability of the health system (40 years down the track).
- Improve partnerships with the mental health and alcohol and drug sectors, and other social services for people who are outside the tertiary hospital sector to the community.

Quality and Value

- Safety and Quality closely linked to sustainability
- The need to start thinking at an evidenced based system level to make decisions on wasteful testing processes; we have the data and methodology now to make this change

Workforce and Culture

- Culture that supports taking risks is required
- Cultural issues and transparent reporting of issues is critical
- Leadership skills and positions are critical not just balancing the budget
- Nurse and midwives are an untapped resource to provide care closer to home
- Supervision critical for steering/directing junior staff and MD teams who veer from efficient care when under financial pressures.
- We can't just continue evolutionary change; we need an environment for nurturing fundamental changes and a platform for conversations with primary care.
- Education and training of workforce for the future- new roles, broader system approach, efficient care and dynamic leadership**.**

Financial Sustainability

- Consideration of areas of waste across the system – i.e. Choosing Wisely and reduce duplication of diagnostic testing between systems of care
- Cap health expenditure in WA budget at 30%.
- Consider preventable hospitalisation targets and environmental contributor target
- Set specific measurable targets for improving sustainability of the system
- Need for outcomes based funding which involves navigating the State/Commonwealth and public/private issues to put patients first
- Behavioural change around use of consumables in health services
- Need to get rid of ABF disincentive that relies on average LOS if we're to reduce chronic admissions and improve the focus on primary care
- Employ financial experts to tweak our approaches to work around ABF (e.g. GPs skype vs phone calls)
- Competition within own health services and with other hospitals.
- Sustainability of the two systems- public and private – need to look broader
- Reduction in duplications- repetition of tests when patients move between public and private systems. Reduction in paper payslips for all staff**.**

Digital, Innovation and Research

- Leadership needed to roll out technological systems that talk to each other
- System redesign and disruption that has an evidence based need to not be opt-in but rather legislated
- Research is critical to informing future sustainability
- Use of data and research to inform future sustainability
- Using data more efficiently is critical to engage with clinicians and reduce costs
- People's time and skillsets are needed to tackle complex clinical issues
- A telehealth future may need to skip a generation but even so we need to be agile in adopting technology and getting on the front foot
- A single patient record with adequate information for transfer between services is critical
- Electronic medication prescribing system to coordinate medication but also have insightful data to make good decisions
- A technologically enabled home monitoring future in remote areas has required a cultural shift for specialist and GP relationships

Working groups – key metrics for system change

To inform metrics for system change senators were posed the following statement:

We will know we have a sustainable health system when…

Senators were ask to complete this statement and, after doing so, to discuss and formulate measures of success. Their suggestions were organised into the six SHR themes:

- Patients, Pathways and Experience
- Prevention, Promotion and Partnerships
- Quality and Value
- Workforce and Culture
- Financial Sustainability
- Digital, Innovation and Research

Senators developed 85 outcomes and in excess of 250 metrics to validate success in achieving a sustainable health system through reform.

Completed statements under these themes and the diversity of recommended metrics can be found with the full list at Appendix 4.

The Clinical Senate of WA strongly recommends the SHR consider all metrics developed.

What follows are examples of the key outcomes and metrics. (Appendix 4 Full list)

Theme	**Outcomes and examples of metrics** *We will know we have a sustainable health system when…*
Patients, Pathways and Experience	**When patients are empowered to access and contribute to their own health information.** Goals of Care or Advanced Health Directives (AHD) for every patient (number or percentage) EHR accessed by patients and all providers (primary, public, private hospital, aged care) (%)
	When the patient experience is acknowledged, measured and the outcomes are available in the public domain. Proportion of feedback (complaints) that results in change in area health service practices
	When the impact of chronic disease reduces and is demonstrated by a reduction in Disability Adjusted Life Years (DALY) attributable to i.) ischaemic heart disease, ii) chronic pulmonary disease, iii) diabetes
	When primary care is first and foremost WA and measured by GP satisfaction with hospital communication 100% Discharge summary completion rates and receipted Rates of ED presentations in triage 4 and 5 are reduced to 5% total presentations
	When hospital in the home beds are greater than traditional hospital beds. Number, percentage and occupancy of Hospital in The Home (HITH) beds

Prevention, Promotion and Partnerships	**When the acute sector and primary care work together to improve patient pathways and health outcomes.** Number of programs and partnerships delivering collaborative care with agreed health outcomes (health quicker, cheaper, closer to home)
	When Aboriginal people enjoy the same health as the mainstream population. Aboriginal people have the same life expectancy and health outcomes as the non- Aboriginal community
Quality and Value	**When interventions not endorsed by Choosing Wisely are disinvested.** Expenditure on non-endorsed interventions Percentage of compliance with Choosing Wisely strategies
	When unwarranted duplication has been eliminated. Re-order rates/percentages across private and public
	When there is zero healthcare associated harm to patients. Classification of Hospital Acquired Diagnoses (CHADx)
	When there is seamless transition from acute to primary healthcare. Proportion of handover to GP GP satisfaction with hospital communication Proportion of patients with discharge summaries GP review of discharge summaries within timeframe Measure of patient satisfaction with transition
Workforce and Culture	**When WA Health is the employer of choice for healthcare workers as rated *by healthcare workers.*** All positions filled Reduced OSH stress and absenteeism Staff satisfaction is >70% Access to teaching and training Timely recruiting processes and practices within 4 weeks Leading staff engagement scores on benchmarked tools
	When WA Health is the employer of choice for healthcare workers as rated *by the system.* Vacancy rate across all areas of care delivery – professional and non-professional staff is low Low staff turnover Research output is high Peer comparisons rank WA Health as a system leader

	When WA Health is an employer of choice by *International reputation.* World leading in clinical care Percentage of research papers published Uptake Nationally and Internationally of innovative change State, National and International compliance with accreditation standards and measures of safety
	When there is evidence of effective working partnerships between consumer, GP, Primary Health Networks (PHN) and tertiary services. Memorandum of Understanding (MOU) in place between Health Service Providers (HSPs) and Aboriginal Health Council of Western Australia (AHCWA) MOU in place between HSPs and WA Primary Health Alliance (WAPHA)
	When society has confidence that all health care does not have to be provided in an acute care setting. Percentage of care delivered outside a hospital setting Investment in non-hospital centres health care delivery services and locations by government When consumers can identify a transparent link between GPs and specialists
Financial Sustainability	**When healthcare costs are related to clinical and patient reported outcome measures.** Costs of testing/treatment are displayed in the public domain Report the amount of spend on unnecessary duplication of services and reduce it by X percentage Transparency of costs over the full cycle of care is identified
	When healthcare costs are transparent to both consumers and clinicians. Patient Reported Outcome Measures (PROMs) at head of service level Budgets at head of service level Consumer Advisory Councils are aware of the financial status of health
	When consumers understand waste in healthcare. Reduction in consumer requests for futile care or non-evidence based services
	When the proportion of waste to the total health spend is reduced by at least X% per year. Compliance reporting against “on tender” purchasing Compliance reporting against the use of “off tender” request processes Contract managers in every Health Service Provider (HSP)

Digital, Innovation and Research	**When we have real-time prescribing.** Clinician access to real-time prescribing (including decision support). Percentage
	When 'inpatients' can be monitored at home. Reduction in Length of Stay (LOS) Cap on hospital beds

Closing remarks

"Ultimately, as clinicians and users of the system, your quality of life will rely on the sustainability of the health system".

Ms Robyn Kruk offered her final thoughts thanking senators for their participation and for their commitment to ensure the balance is maintained. She stated she was confident that she and her team had heard the messages and, along with the metrics to be collated after the debate, the senate's outcomes will inform the SHR, its reports and final outcomes.

Deputy Chair, Dr Jeanette Ward closed the session reminding senators of the recommendations from the 2016 Clinician Engagement debate and, as evident during the debate, the continued benefits when planning reform of consulting a broad range of clinicians. She agreed that the health budget cannot consume any more than 30% of the WA state budget. Participants had also been reminded that the community also wants a sustainable health system - and not just a report which is never actioned. What had come through discussions and recommendations was the need to invest in and liberate people in the system and, as found in the pre-debate survey, clinicians are clearly vested in WA health's success.

Professionals from all domains of practice play an integral part in the patient journey and delivery of health services.

A health system focussed on quality and safety will be a better health system, cost less and deliver better outcomes.

Chair's reflection

It was refreshing and reassuring that, through this process, the clinician-dominated forum did not identify any major variation in themes to those chosen by the SHR and those used in the wider community consultation processes.

We do not have to justify what needs to be considered to embed change. We do not need to argue why the change is necessary. We all recognise the success of a sustainable health system requires a multi-pronged approach around the themes identified.

To ensure success it will require strong leadership with reported outcomes. We must reduce waste by creating a safe, quality driven system and we must engage with our consumers and our partners to maximise efficiency.

The unique experiences gained from the implementation of Reid, the overlap of what has been reported in the Professor Hugo Mascie-Taylor report coupled with the SHR is fundamental to delivering Western Australians with a safe, sustainable health system for the future.

The Clinical Senate outcomes will inform the Sustainable Health Review Panel and have clearly identified the metrics for success.

Appendices

Appendix 1: Full Program

Destination: Sustainability

Monday 20 November 2017

Fraser's Function Centre, 60 Fraser Avenue
Kings Park, Western Australia

7:45am – 8:30am	**Registration**	**Tea & coffee**

8:30am – 9:35am Presentations

Executive sponsor:	**Ms Robyn Kruk AM, Chair, Sustainable Health Review**	
Facilitators:	**Clinical Adjunct Associate Professor Kim Gibson and Mr Will Bessen**	
8:30am	Welcome to Country	Ms Marie Taylor
8:35am	Welcome and senate update	Ms Tanya Basile
8:45am	Director General's response to clinical indicators and introduction of Ms Robyn Kruk AM	Dr David Russell-Weisz
8.55am	Setting the scene for debate	Ms Robyn Kruk AM
9:15am	The clinician perspective	Dr Hannah Seymour
9:25am	The consumer perspective	Ms Pip Brennan
9:35am-10:10am	**Group map session**	Mr Will Bessen

10:10am- 10:35am	**Morning tea**

10:35am – 12:15pm – Plenary – Destination: Sustainability - The critical conversations

Additional Expert Witnesses	Dr Simon Towler, Clinical Associate Professor Susan Benson, Dr Jodi Graham, Dr Joel Tate, Mr James Aitken, Professor Fiona Lake, Dr Phil Montgomery, Dr Audrey Koay, Dr Susan Slatyer, Dr Greg Sweetman, Ms Linda Sinclair, Ms Monica Taylor, Ms Trish Morrell, Ms Rebecca Brown, Ms Kerry Fitzsimons and Mr Ryan Sengara.
Invited Guests	Dr Neale Fong, Professor Geoff Dobb and Clinical Professor Mark Khangure.

12:15pm – 1:00 pm	**Lunch**

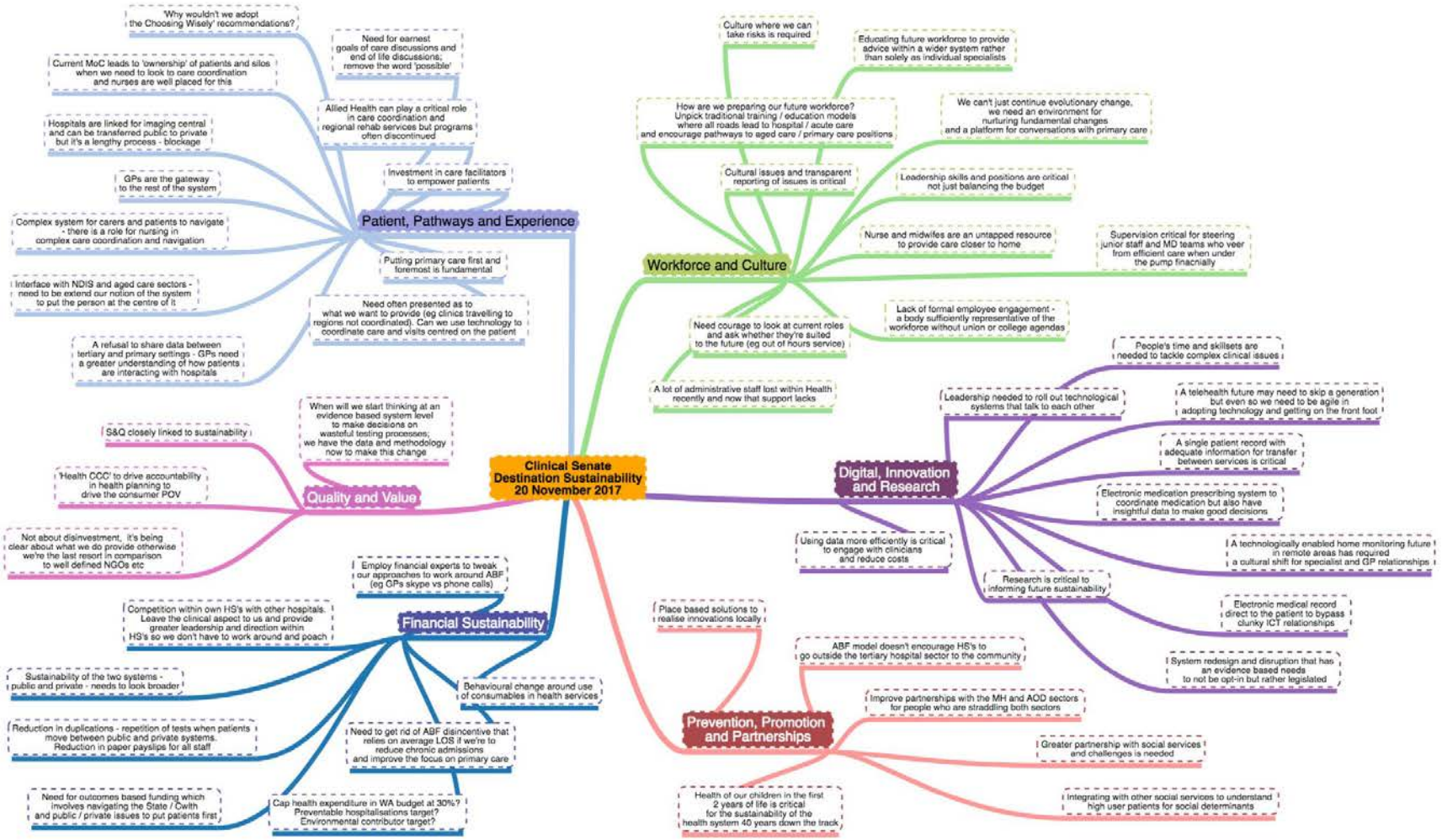
2:50pm- 3:30pm Final Session

2:50pm	Feedback, discussion and summary of outcomes	Clinical Adjunct Associate Professor Kim Gibson Mr Will Bessen
3:10pm	Closing remarks	Ms Robyn Kruk AM
3:25pm	Deputy Chair's summary	Dr Jeanette Ward
3:30pm	Close	

Appendix 2: Presenters and Expert Witnesses

- Ms Marie Taylor, Nyungar Aboriginal Elder
- Ms Tanya Basile, Chair, Clinical Senate of Western Australia
- Dr David Russell-Weisz, Director General , Department of Health, WA
- Ms Robyn Kruk AM, Independent Chair, Sustainable Health Review
- Dr Hannah Seymour, Chair, Clinical Reference Group, Sustainable Health Review
- Ms Pip Brennan, Chair, Consumer and Carer Reference Group, Sustainable Health Review
- Adjunct Associate Professor Simon Towler, Clinical Services, Fiona Stanley Hospital
- Clinical Associate Professor Sue Benson, Consultant Clinical Microbiologist, Infectious Diseases Physician, PathWest, Fiona Stanley Hospital
- Dr Jodi Graham, Medical Advisor, Sustainable Health Review
- Dr Joel Tate, Geriatrician, Armadale Health Service
- Mr James Aitken, Consultant General Surgeon, Sir Charles Gairdner Hospital
- Professor Fiona Lake, Eric Saint Professor of Medicine and Respiratory Physician, Sir Charles Gairdner Hospital
- Dr Phil Montgomery, Regional Medical Director, WA Country Health Service - Pilbara
- Dr Audrey Koay, Executive Director, Patient Safety and Clinical Quality, Department of Health, WA
- Dr Susan Slatyer, Research Fellow, School of Nursing, Midwifery and Paramedicine, Curtin University
- Dr Greg Sweetman, Director of Medical Education, Fiona Stanley Hospital
- Ms Linda Sinclair, Acting Coordinator of Nursing, WA Country Health Service
- Ms Monica Taylor, Service Director, Mental Health, Armadale Kalamunda Group
- Ms Trish Morrell, A/Director, Business Performance, Department of Health, WA
- Ms Rebecca Brown, Deputy Director General, Department of Health, WA
- Ms Kerry Fitzsimons, Medication Safety Pharmacist, Pharmacy Department, Fiona Stanley Hospital
- Mr Ryan Sengara, Director of Strategy, Department of Health WA
- Professor Geoff Dobb, Deputy Chair, Child and Adolescent Health Service Board
- Clinical Professor Mark Khangure, Board Member, South Metropolitan Health Service Board
- Dr Neale Fong, Chair, WA Country Health Service Board

Appendix 3: Mind Map



Appendix 4: Outcomes and Metrics

We will know we have a sustainable health system when …

	Outcomes	Metrics
	Patients, Pathways and Experience	
1.	When patients are empowered to access and contribute to their own health information.	– Electronic Health Record (EHR) accessed by patients and all providers (primary, public, private hospital, aged care) (%) – Goals of Care or Advanced Health Directives (AHD) for every patient (number or percentage) – Every admission form to include a prompt to consider whether a patient requires an Advanced Health Directive
2.	When a person enters the healthcare system an EHR with a unique identifier is established.	– Percent of contact with a health service and percent of EHRs established. Target = 100 %
3.	When the patient experience is acknowledged, measured and the outcomes are available in the public domain.	– Patient experience data is reported publically – Consistent feedback on the patient experience is implemented across all health facilities – Patient Opinion® is promoted to at least 80% of patients across all health facilities – All comments on Patient Opinion® are responded to. – 100% compliance by Health Services (HS)/Health Service Providers (HPSs) with implementation of the WA Carers recognition Act 2004 policy – Proportion of feedback (complaints) that results in change in area health service practices – There is evidence of the use of culturally appropriate feedback systems
4.	When diverse patient groups are catered for.	– Life expectancy of Aboriginal populations equals that of non-Indigenous – 50% of aboriginal people are cared for by an aboriginal strong health workforce with 10 years – All health specialities and disciplines have Telehealth capability – All health facilities are 100% compliant with the WA Health System Language Services Policy – Percent measure
5.	When culturally appropriate methods of measuring patient experience and feedback systems are available in all health facilities.	– Percentage of feedback from marginalised groups
6.	When the role of the carer is seen as a partner in the delivery of health care.	– 100% compliance by HS/HSPs with implementation of the WA Carers recognition Act 2004 policy
7.	When the consumer voice is recognised and is part of service planning and service review at every level of health delivery.	– Compliance reporting of consumer engagement at the decision making tables – All HS/HSPs demonstrate active consumer engagement programs/strategies – Consumer representation is present at all levels of service planning and service reviews
8a.	When the patient experiences a holistic and seamless delivery of health care.	– Timeliness of information exchange (e.g. discharge summary completion rates, timeliness of outpatient letters/correspondence) – Access to investigation results Investigation results are

8b.	When patients transfer or travel is seamless and timely, and patient transport providers are seen as integrated within the overall health service.	reported in 100% of inpatient discharge summaries and 100% of outpatient correspondence letters. – Percentage of complex care patients having a care coordinator – Integrated and state-wide Patient Assisted Travel Scheme (PATS) program Centralisation of the PATS
9.	When the impact of chronic disease reduces.	– A reduction in Disability Adjusted Life Years (DALY) attributable to i) Ischaemic heart disease, ii) chronic pulmonary disease, iii) diabetes – All HS/HSPs, in conjunction with the primary health and non-government organisation (NGO) sector, have a chronic disease self-management program in their health facilities – All HS/HSPs implement a chronic disease coordination program for patients with 2 or more conditions listed by WA Health as being amenable to preventative measures – There is an integrated care pathway for every patient with chronic disease with clearly articulated tiers of care needs
10.	When primary care is put first and foremost.	– GP satisfaction with hospital communication – 100% Discharge summary completion rates and receipted – 100% of GP referrals to outpatients have documented communication back to the GP – Immediate access to specialist advice for clinicians in primary health care is available in all health services. This will mean the patient does not require admission and the clinician is upskilling and building capacity – Transition of care to and from primary to secondary / tertiary systems is seamless as reported by the patient or family – Funding follows the patient pathway – Rates of ED presentations in triage 4 and 5 are reduced to 5% of total presentations
11.	When hospital in the home beds are greater than traditional hospital beds.	– Number, percentage and occupancy of Hospital in The Home (HITH) beds
12.	When the acute sector and primary care work together to improve patient pathways and health outcomes.	– Number of programs and partnerships delivering collaborative care with agreed health outcomes (health quicker, cheaper, closer to home) – MOU in place between HSPs and Aboriginal Health Council of WA (AHCWA) – MOU in place between HSPs and WA Primary Health Alliance (WAPHA) – Reduction in Waiting times for individuals with substance abuse disorders
13.	When the variations to achievable health outcomes across regions are made clear and transparent to consumers.	– Clinical variation mapping and reporting in the public domain
14.	When consumers have increased health literacy.	– Demonstrated increase in the uptake of AHDs and Goals of Care – Demonstrated increase in the use of Patient Opinion®
15.	When all patients admitted to aged care have an AHD in place and linkages back into tertiary and primary health networks.	– Record counting compliance rates
16.	When WA Health prioritises Investment in infant, child health and youth.	– Decrease in waiting periods for outpatient appointments and intervention for children and adolescent patients – Decrease wait between diagnosis and intervention – When all HS/HSPs quarantine funding for early intervention

		for the 0-2 year old age cohort
17.	When the incidence of risk factors attributable to chronic disease decreases.	– Decrease prevalence of harmful alcohol use by 20% based on public sales following Public Health campaign – Increase the prevalence of WA persons who meet the Australian Dietary Guidelines recommendations for daily fruit and vegetable intake – Increase the prevalence of WA persons who meet sufficient levels of physical activity
18.	When we can ensure birthing practices are appropriate and evidence based.	– Benchmark Caesarean rate with other states – Increase access to continuity of midwifery carer model (number of health services offering the model, number of women and percentage receiving care in the model)
19.	When vaccine preventable conditions decrease.	– Percent of fully immunised children reaches >95 in all age groups – Health care worker influenza vaccination rates reaches 70% – Adolescent vaccination rates reaches 90% – Pneumococcal and influenza vaccination status is recorded for All at risk patients on admission
20.	When Area Health Services have partnerships with local councils.	– Health focused MOU – public support for health education, harm minimisation and fitness programs – Number of programs – Percentage of working parties with consumer/ carer representation
21.	When there is a process/system for development of state-wide evidence based clinical guidelines with clinical content experts/specialists drawn from health service.	– Measure across site Professional Development (PD) Opportunities – Measure across site patient outcomes for specific health conditions e.g. asthma
22.	When an increased percentage of health dollars are allocated to research and education at a rate of 5 to 8%.	– Proportion of budget allocated to research and education by each health service

	Prevention, Promotion and Partnerships	
1.	When the acute sector and primary care work together to improve patient pathways and health outcomes.	– Number of programs and partnerships delivering collaborative care with agreed health outcomes (health quicker, cheaper, closer to home) – MOU in place between HSPs and AHCWA – MOU in place between HSPs and WAPHA – Increased number of GP clinics co-located near ED Departments – Measure of integrated care pathways for every patient with chronic disease that articulates care needs
2.	When Aboriginal persons enjoy the same health as the mainstream population.	– Aboriginal populations have the same life expectancy and health outcomes as the non-Aboriginal community
3.	When consumers have increased health literacy.	– Demonstrated increase in the uptake of AHDs and Goals of Care – Demonstrated increase in the use of Patient Opinion – Active participation in setting Goals of Care
4.	When we work with communities to better meet their health care needs.	– All HS/HSPs demonstrate active consumer engagement programs/strategies – Consumer representation is present at all levels of service planning and service reviews – The engagement of GPs in care partnership
5.	When Hepatitis C is eliminated within 10 years.	– Increase in uptake of Hepatitis C treatment – Decrease in waiting time for hepatology outpatient appointments for Hepatitis C treatment – Decrease in hepatitis failure caused by hepatitis C
6.	When the incidence of risk factors attributable to chronic disease decreases.	– Decrease the prevalence of smoking rates – Decrease the prevalence of obesity in children and adults – Decrease in drug and alcohol related conditions – Decrease alcohol sales as a measure – Decrease prevalence of harmful alcohol use – Increase the prevalence of WA persons who meet the Australian Dietary Guidelines recommendations for daily fruit and vegetable intake – Increase the prevalence of WA persons who meet sufficient levels of physical activity
7.	When vaccine preventable conditions decreases.	– Percentage of fully immunised children reaches >95 in all age groups – Health care worker influenza vaccination rates reaches 70% – Adolescent vaccination rates reaches 90% – Pneumococcal and influenza vaccination status is recorded for All at risk patients on admission
8.	When there is a strong partnership with local councils, education, housing, justice to address the social determinants of health.	– Regular round table meetings between agencies to identify and address local issues with accountability to Parliament – Improved health literacy – Number of Health promotion community run programs – Presence of interagency committees
9.	When there is evidence of effective working partnerships between consumer, GP, Primary Health Networks (PHN) and tertiary services.	– E health record in place and owned by the patient – 100% discharge summary on discharge – Reduction in unnecessary readmission to tertiary healthcare – Decease in presentations of Triage score 4 and 5 in tertiary Emergency Departments (EDs)
10.	When we can improve care for individuals with substance abuse disorders.	– Reduced waiting time for programs supporting individuals with substance abuse disorders
11.	When all patients admitted to aged care have an AHD in place and linkages back into tertiary and primary health networks	– Audit of admission records demonstrates 100% compliance with AHD recording

12.	When Patient experience is valued.	– Patient experience is measured across the whole patient journey and care centres
13.	When an increased percentage of health dollars needs to be allocated to research and education at a rate of 5 to 8%.	– Percentage of budget – Proportion of budget allocated to research and education by each health service

	Quality and Value	
1.	When there is zero healthcare associated harm to patients.	– Measure and outcome reporting of all Severity Assessment Codes (SAC) 1s at HSPs – Classification of Hospital Acquired Diagnoses (CHADx)
2.	When unwarranted duplication has been eliminated.	– Re-order rates/percentage across private and public – Periodic audits of elective surgery admissions to assess co-ordination of pathology / x-rays and corroborate reduction of duplication – Standardisation of protocols and policies across services including public / private services – Accessing results is faster than reordering tests
3.	When interventions not endorsed by Choosing Wisely are disinvested.	– Expenditure on non-endorsed interventions – Percentage of compliance with Choosing Wisely strategies.
4.	When patient services are efficiently used.	– Proportion of patients who need to return for test results – Percentage that come back multiple times for the same referral
5.	When there is a transparent process involved with high cost “low value” interventions.	– Reportable costs with overseeing panel for each site – Percentage of decisions which have appropriate authorisation – Patient understanding of health care decisions – Public reporting on waste
6.	When there is seamless transition from acute to primary healthcare.	– Proportion of handover to GP – GP satisfaction with hospital communication – Proportion of patients with discharge summaries – GP review of discharge summaries within timeframe – Measure of patient satisfaction with transition.
7.	When all patients have Goals of Care / Advanced Health Directive.	– Percentage of patients who have documentation of Goals of Care
8.	When both clinicians and consumers agree on the measure of safety and access to services .	– Agreed indicators across WA health for each specialty with consumer endorsement – Agreed wait times for elective procedures, clinical referral, access to a specialist
9.	When clinical staff are adequately supported in administrative duties.	– Percentage of administrative support provided to clinician managers/Heads of Departments (HoDs) – Clinicians’ satisfaction with administrative support provided to their teams to support patient care – Time in motion studies for clinician management to review time spent of duties that could be performed by clerical/administrative business/HR staff
10.	When staff engagement is effective.	– Staff retention – Sick leave – Staff feedback – WA Health policies for dealing with bullying and disrespectful behaviour at senior level are contemporary and implemented – Culture surveys demonstrate consensus regarding ‘above’ and ‘below’ the line behaviours with mandatory consequences
11.	When staff are working to their scope of practice (i.e. cutting out lower value tasks, able to divulge tasks to the most appropriately skilled person, not sending patients back to GP for specialist referral/ imaging, removing the barriers e.g. advanced scope roles).	– Reduced wait times for services – Reduced point of contact for an episode of care – Improved staff satisfaction.
12.	When WA Health has a suite of endorsed indicators to benchmark and measure	– MyHospitals indicators – WA Emergency Access Target (WEAT) >80%

	quality of services.	– >90% children aged 5 are fully vaccinated – Preventable admissions are <5%
13.	When clinicians are given real time data on their performance and benchmarked against their peers, and made publicly available.	– Atlas of Variation
14.	When WA Health is meeting the National Efficient Price (NEP).	– Measure against the Independent Hospital Pricing Authority (IHPA) and track reason for variation

	Workforce and Culture	
1.	When WA Health is the employer of choice for healthcare workers as *rated by the system*	– Vacancy rate across all areas of care delivery – professional and non- professional staff is low – Low staff turnover – Research output is high – Peer comparisons rank WA Health as a system leader
2.	When WA Health is the employer of choice *by healthcare workers*	– Increased retention rate – Leading staff engagement scores on benchmarked tools – All positions filled – Reduced OSH stress and absenteeism – Increase in substantively filled roles and reduction in acting percentages for staff – Staff satisfaction is >70% – Sick leave rates – Lost time to injury rates – Proportion of vacancies, permanent, acting – Access to teaching and training – Increased access to flexible working hours – Timely recruiting processes and practices within 4 weeks
3.	When WA Health is an employer of choice *by International reputation*	– World leading in clinical care – Percentage of research papers published – Uptake Nationally and Internationally of innovative change – State, National and International compliance with accreditation standards and measures of safety
4.	When staff wellbeing programs are embedded into the Heath service.	– Presence of staff welfare programs and number of staff accessing them – Increased rates of reporting incidents and hazards – Access to further development programs
5.	When managers and leaders have leadership training.	– When 80% of managers have management training (20 hours) – Leadership training completion rates (% of all in leadership positions)
6.	When Leadership programs are linked with performance development processes / plans	– Percentage of staff that have undertaken leadership development plans
7.	When we have the right people, providing the right care in the right place	– Baseline workforce metrics: demographics and skill mix measures – Benchmark cost of episodes of care – Agreed acceptable low volume service delivery locations
8.	When innovation is integral to culture.	– Establishment of innovations department – Innovations are shared system wide and state wide – When innovation becomes a Health Service Provider Report (HSPR) Key Performance Indicator (KPI) – Incentives for IT software and hardware solutions from a university level
9.	When all members of the health workforce feel valued equally.	– Investment in leadership and development programs – Investment in career development pathways – Development of assistant models to relieve the non-clinical workload – Representation of all health professionals on key decision making committees – Salary scales for leadership roles should be the same regardless of awards (AMA, HSU or ANF or professional background)
10.	When skill mix is appropriate for patient demand.	– Continue targets to increase percentage of Aboriginal workforce

		– Increased advance practice roles for non-medical staff
11.	When we are able to appropriately manage poor performance.	– All employees have appropriate performance planning and self -directed appraisal – Number of employees being performance managed – Evidence of managing substandard performance is a recruitment criteria for managerial positions – HR support is available in 100% of substandard performance management processes. – Establishment of WA Health 'above' and 'below' the line behaviours with mandated consequences – Recruitment and dismissal processes are values based 100% of the time
12.	When society has confidence that all health care does not have to be provided in an acute care setting.	– Percentage of care delivered outside a hospital setting – Investment in non-hospital centres health care delivery services and locations by government – When consumers can identify a transparent link between GPs and specialists.
13.	When undergraduate training for all clinicians commences with a common base unit(s) and shared training. Individuals then take on further training (i.e. Nursing, Medicine)	– Number of units that provide Inter Professional Learning (IPL)

	Financial Sustainability	
1.	When healthcare expenditure does not grow beyond Consumer Price Index (CPI).	– Expenditure as a percentage of state budget – Expenditure as a percentage of Gross domestic product (GDP)
2.a	When healthcare costs are transparent to both consumers and clinicians.	– Patient Reported Outcome Measures (PROMs) at head of service level – Budgets at head of service level – Consumer Advisory Councils are aware of the financial status of health
2.b	When healthcare costs are related to clinical and patient reported outcome measures.	– Costs of testing/treatment are displayed in the public domain – Report the amount of spend on unnecessary duplication of services and reduce it by X percentage – Transparency of costs over the full cycle of care is identified
2.c	When consumers understand waste in healthcare.	– Reduction in consumer requests for futile care or non-evidence based services
3.	When there are bundled payments for GPs over the whole cycle of care.	– Number of (chronic disease) Diagnosis Related Groups (DRGs) with bundled payments – Number of DRGs with bundled payments – Number of GPs receiving bundled payments for patients with chronic diseases
4.	When the Head of Service is a recognised position and those in these roles are adequately educated to be accountable for these budgets	– All allocated budgets will be with 5% of expenditure to forecast – All Head of Departments have completed financial education within 12 months of assuming the role
5.	When population health funding is quarantined and separated from hospital budgets for each area rather than a hospital budget.	– Improvements in access to care – Rates of sentinel complications related to number of DRG funded patients – Reductions in Potentially Preventable Hospitalisations (PPH) – Percentage of the health budget allocated to preventative activities
6.	When WA Health has a clear understanding of its finances.	– Robust tools – Robust metrics – Connected finance reporting systems
7.	When the proportion of waste to the total health spend is reduced by at least X% per year.	– Compliance reporting against “on tender” purchasing. – Compliance reporting against the use of “off tender” request processes. – Contract managers in every HSP
8.	When costs of care are transparent to both consumers and clinicians, and are related to clinical and patient reported outcomes.	– Cost related to the National Efficient Price (NEP) target – Unplanned readmission at 30 days or within 24 hours – Standardised adverse events measures per discipline – Patient reported outcomes per discipline (e.g. International Consortium for Health Outcomes Measurement (ICHOM) scores per discipline) – When the amount of spending on treatments are <u>not</u> endorsed by Choosing Wisely
9.	When the consumers lead the decisions	– Each HSP Board engages consumer members on financial

	on where the budget for health care is spent.	decisions – Number of citizens juries held to discuss health spending – Community Advisory Councils or similar in every health service – Audit the consumer understanding of “informed consent” annually and n=200
10.	When clinicians have timely access to specialist advice that reduce unnecessary tests and/or hospitalisation.	– Reduction in Length of Stay (LOS)

	Digital, Innovation and Research	
1.	When 'inpatients' can be monitored at home.	– Reduction in Length of Stay (LOS) – Cap on hospital beds – No increase in tertiary/ general hospital beds. An absolute cap on available hospital beds
2.	When home monitoring with a system that includes patient GP, nurse specialist working collaboratively with real time data to maximise patient outcomes is embedded everywhere.	– 60% of homes of people with chronic complex conditions have home monitoring connected to their health care team within 2 years
3.	When we have real-time prescribing.	– Reduction in inappropriate prescriptions S4 and S8 medications – Clinician access to real-time prescribing (including decision support) % – Scripts filled through real-time prescribing % – Contemporary decision support systems are promoted – Accreditation affirms high-quality decision support leading the country
4.	When research is integral, funded and demonstrates improvement in health outcomes.	– The data is linked to the performance of the health service – A percentage of HSP budgets be quarantined for research activity – Metrics are developed to corroborate translational research relevant to health facility priorities – Promote evidence-based decision-making throughout the system by developing 'markers' of evidence-based treatment and monitoring its delivery – Statewide clinical guidelines – A measure of health funded research
5.	When we have effective research transfer.	– Variation outside evidence based guidelines diminishes over time
6.	When innovation incubation occurring throughout the health system and is visible, valued and when demonstrated to be effective, has a pathway to scaling up and embedding.	– 1.5% of HSP budgets are quarantined for innovation and embedding
7.	When HSP policies and procedures enable uptake of new social technology for patient benefit and fully imbedded in day to day business (metro and rural)	– When all specialist first follow up assessments are done by telehealth/ percentage of subsequent visits. Reduction in PATS expenditure/ usage
8.	In regions of aboriginal population density, Aboriginal Health Practitioners use all available IT to serve their communities.	– 100% Aboriginal Health Practitioners report they are enabled to use all IT available in their context to the benefit of Aboriginal people
9.	When there are consistent digital systems across all HSPs.	– All health services use same patient administration system, pathology system, imaging system etc. – Staff satisfaction increase – Implementation of a centralised and common patient management system across all health services
10.	When there is a fully functioning e-health record utilised by all health care	– Percentage of health care providers using e-health record – Number of patient records being used health care providers

	providers with ready access to all results, investigations, history, medications etc.	– Reduction in investigation duplication shown by reducing costs – Includes primary health care, public hospital and private hospital care, specialist care – A patient controlled health record – Number of patients using e health record – Data breaches are monitored and sanctions for behaviour outside of policy are implemented by managers
11.	When we have digital systems that allow rapid transfer of information.	– 95% discharge summaries received by GP within 24hrs of discharge
12.	When patients can use existing digital technology to navigate health service sites.	– Patient experience reporting – Number of hits on the App

This document can be made available in alternative formats on request for a person with a disability.